DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/07/2019 FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938	3-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURY COMPLETE	
		08G013	B, WING		07/31/20)19
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE		
	AMBRELL OFNITER			4641 WELDIN RD		
MARYC	AMPBELL CENTER			WILMINGTON, DE 19803		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE COM	(X5) PLETION DATE
W 000	INITIAL COMMENT		W	000		
	conducted at this fathrough July 31, 20 contained in this re observation, intervir and review of other indicated. The facil survey was 48. The residents and one survey was follows:	ew, review of clients' records facility documentation as lity census the first day of the e survey sample totaled three sub-sampled resident.				
	underneath the sca the skull; NHA- Nursing Hom RCT - Resident Car SCM-Senior Case M QIDP - Qualified Int Professional. STAFF TREATMEN CFR(s): 483.420(d) The facility must de policies and proced mistreatment, negle	Director of Nursing; ector; ector; fursing; ematoma -is a bleeding lp in the upper left region of e Administrator; re Technician; Manager; ellectual Disabilities IT OF CLIENTS (1) velop and implement written	W 1	W 149 "The facility must develop a implement written policies of procedures that prohibit mistreatment, neglect or abothe client." SECTION A (Individual Imparesident (R1) was impacted by the deficient practice.	and use of eted)	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) deplotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			Of	MB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY MPLETED
		08G013	B. WING			07	/31/2019
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MARY C	AMPBELL CENTER				1 WELDIN RD LMINGTON, DE 19803		
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W 149	Continued From pa	ge 1	W.	149	W149, continued		¥
	the facility failed to policies and proced current definition for The CMS Intermed Individuals with a stated the definition "Neglect means fail services necessary mental anguish or rintervene appropria behavior may constimplement facility saggression is identification for Identification of Abuse Investigation and Rand Corrective Action (Individuals Individuals Individuals Includes situation neglect: 1. Includes situation neglect: 1. Includes situation neglect if residents incidents caused by a Includes lack of the resident includir bathing, meals and	develop and implement written ures which incorporated the r neglect. Findings included: diate Care Facilities for ellectual Disabilities (ICF-IID) revision date of 4/13/18, for neglect as: ure to provide goods and to avoid physical harm, mental illness. Staff failure to tely to prevent self-injurious citute neglect Staff failure to afeguards, once client to client fied, may also constitute and procedure, titled en Neglect, and Exploitation eporting of Alleged Incidents, on, with a revision date of and Definitions: Regulations g-Term Care Nursing Facilities and exploitation, as on that constitutes evidence of are involved in serious one or more of the following: attention to physical needs of ang, but not limited to toileting,			SECTION B (Identifying Other Residents) All residents had the potential to affected by the deficient practice. SECTION C (System Changes) The facility's "Prevention of Abu Neglect and Exploitation, Investigation and Reporting of Alleged Incidents and Corrective Actions" policy was revised to comply with the CMS definition neglect. (Attachment A) Mary Campbell Center staff, consultan and Unidine Lifestyles partners where trained on the revised policy. SECTION D (Success Evaluation The Executive Director, Director of Nursing and/or Assistant Directon Nursing will review fall incidents ensure there was no evidence of failure to provide goods and servine necessary to avoid physical harm mental anguish or mental illness. An audit tool has been developed reviewing falls to ensure complia with the facility's Prevention of Abuse, Neglect and Exploitation. Investigation and Reporting of Alleged Incidents and Corrective Actions" policy. (Attachment B)	of tts, vill on) a ices	
		the current CMS definition for			Actions poncy. (Attachment B)		

neglect.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/07/2019 FORM APPROVED OMB NO. 0938-0391

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION		TE SURVEY MPLETED
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MARY CAMPBELL CENTER				41 WELDIN RD		
				ILMINGTON, DE 19803		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	at approximately 3: with E1(AED) and E STAFF TREATMEN CFR(s): 483.420(d)	eviewed on 7/31/19 beginning 00 PM, during an exit meeting E2 (DON). IT OF CLIENTS (2)	W 149	W149, continued The review process will begin Augu 19, 2019 and continue until 100% compliance is achieved for six consecutive months. Audit results when the reviewed at quarterly Quality Assessment & Assurance Committee meetings	vill	9-27-1 0
	mistreatment, negle injuries of unknown immediately to the a officials in accordar established procedu			W 153 "The facility must ensure that all allegations of mistreatment, neglec abuse, as well as injuries of unknow source, are reported immediately to administrator or to other officials is accordance with State law through	wn o the in	
	Based on record rethe facility policy and determined that for residents who had a failed to immediatel neglect. Findings in CMS Intermediate C with Intellectual Disawith a revision date definition for neglect "Neglect means fails services necessary mental anguish or manual anguish	one (R1) out of two sampled experienced a fall, the facility y report an allegation of cluded: Care Facilities for Individuals abilities (ICF-IID) Regulations, of 4/13/18, stated the tas: ure to provide goods and to avoid physical harm,		established procedures." SECTION A (Individual Impacted) Resident (R1) was impacted by this deficient practice. On 5/10/19, the RCT's involved in the incident were educated by the DON regarding use proper sling size. SigmaCare (EHR care plans were updated to include sizes for residents who use mechan lifts for transfers. On 5/28/19, the SEducator sent the following Sigmat message to Healthcare staff: "In SigmaCare, under the Residen Summary page, the Transfers opti under the CNA tab has been updated the correct sling size for an residents using the ceiling lift. Ple that the size of the sling is determ by physical therapy. Thank you"	s re e of t) sling nical Staff Care nt ion ted to ny ease not	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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AMPBELL CENTER						
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
Nursing Facilities d exploitation, as follon Neglect: 1. Includes situation neglect if residents incidents caused by a. Includes lack of the resident including bathing, meals and F. REPORTING: alleged abuse (vertany incident involving the reported to the Edutation of the resident involving the reported to the Edutation of the Incidents must be reported to the Edutation of the Incidents must be reported to the Edutation of the Incidents must be reported to the Edutation of the Incidents must be reported to the Edutation of the Incidents must be reported to the Edutation of the Incidents must be reported to the Edutation of the Incidents must be reported to the Incidents must be reported to the Incidents must be reported to the Incidents must be reported that the Incidents of	efine abuse, neglect, and ows: In that constitutes evidence of are involved in serious of one or more of the following: attention to physical needs of one of the physical needs of one of the following: attention to physical needs of one of the following: attention to physical needs of one of the following: attention to physical needs of one of the following: affety 3Any incident involving one of the following: affety 3Any incident involving one of the following: affet the occurs of the following: affet the occurs. All other alleged eported within 8 hours" clinical record, the facility's the facility's investigation one: d to the facility with diagnoses and adjustment disorder. the facility's Accident Report of the facility's Accident Report of the facility of th	W	153	W 153, continued SECTION B (Identifying Other Residents) All residents had the potential to affected by the deficient practic Falls from 5/1/19-7/31/19 will be audited using the Audit for Tags W-153, 3201.9.6 Tool to identifialls that may have been the resof neglect. If the audit of fall documentation reveals evidence neglect, the incident will be immediately reported to the	e. oe s îy ult	
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa Nursing Facilities d exploitation, as follo Neglect: 1. Includes situatio neglect if residents incidents caused by a. Includes lack of the resident includir bathing, meals and F. REPORTING: alleged abuse (vert any incident involvir be reported to the D but no later than tw allegation/incident of incidents must be re Cross refer W 149. The review of R1's incident report and revealed the followi 4/1/01 - R1 admitte including epilepsy at 5/9/19 9:00 PM - Tr documented that R bed from a shower through the sling. If his/her head on the nurse who immedia "resident reported resident was transp evaluation," "Contr involuntary spasms	TOF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08G013 PROVIDER OR SUPPLIER AMPBELL CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 Nursing Facilities define abuse, neglect, and exploitation, as follows:	AMPBELL CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 Nursing Facilities define abuse, neglect, and exploitation, as follows: Neglect: 1. Includes situation that constitutes evidence of neglect if residents are involved in serious incidents caused by one or more of the following: a. Includes lack of attention to physical needs of the resident including, but not limited to toileting, bathing, meals and safety F. REPORTING:3Any incident involving alleged abuse (verbal, physical or emotional) or any incident involving serious bodily injury must be reported to the Division of Health Care Quality, but no later than two hours after the allegation/incident occurs. All other alleged incidents must be reported within 8 hours" Cross refer W 149. The review of R1's clinical record, the facility's incident report and the facility's investigation revealed the following: 4/1/01 - R1 admitted to the facility with diagnoses including epilepsy and adjustment disorder. 5/9/19 9:00 PM - The facility's Accident Report documented that R1 was being transferred into bed from a shower chair using a sling and R1 fell through the sling. R1 appeared to have hit his/her head on the floor, E6 (RCT) notified the nurse who immediately performed assessment. "resident reported pain in back of head, resident was transported to hospital for evaluation." "Contributing factors: resident has involuntary spasms."	TOF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER	IX1) PROVIDER SUPPLIER 08G013 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 3 Nursing Facilities define abuse, neglect, and exploitation, as follows: Neglect: 1. Includes situation that constitutes evidence of neglect if residents are involved in serious incidents caused by one or more of the following: a. Includes lack of attention to physical needs of the resident including, but not limited to tolleling, bathing, meals and safety. F. REPORTING:3Any incident involving alleged abuse (verbal, physical or emotional) or any incident involving serious bodily injury must be reported to the Division of Health Care Quality, but no later than two hours after the allegation/incident occurs. All other alleged incidents must be reported within 8 hours" Cross refer W 149. The review of R1's clinical record, the facility's incident report and the facility's investigation revealed the following: 4/1/01 - R1 admitted to the facility with diagnoses including epilepsy and adjustment disorder. 5/9/19 9:00 PM - The facility's Accident Report documented that R1 was being transferred into bed from a shower chair using a sling and R1 fell through the sling. R1 appeared to have hit his/her head on the floor, E6 (RCT) notified the nurse who immediately performed assessment. resident reported pain in back of head, resident was transported to hospital for evaluation." "Contributing factors: resident has involuntary spasms."	AMPBELL CENTER SUMMARY STATEMENT OF DEFICIENCY IN INFORMATION IN 153 REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 Nursing Facilities define abuse, neglect, and exploitation, as follows: Includes situation that constitutes evidence of neglect if residents are involved in serious incidents caused by one or more of the following: a. Includes slack of attention to physical needs of the resident including, but not limited to tolieting, bathing, meals and safety. F. REPORTING:3Any incident involving alleged abuse (verbal, physical or emotional) or any incident involving serious bodily injury must be reported to the Division of Health Care Quality, but no later than two hours after the allegation/incident occurs. All other alleged incidents must be reported within 8 hours" Cross refer W 149. The review of R1's clinical record, the facility's incident report and the facility's investigation revealed the following: All/101 - R1 admitted to the facility with diagnoses including epilepsy and adjustment disorder. 5/9/19 9.00 PM - The facility's Accident Report documented that R1 was being transferred into bed from a shower chair using a sling and R1 fell through the sling. R1 appeared to have hit his/her head on the floor, E6 (RCT) notified the nurse who immediately performed assessment. "resident reported pain in back of head, resident was transported to hospital for evaluation." "Contributing factors: resident has involuntary spasms."

Statement by E6 (RCT) documented "...while

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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	PROVIDER OR SUPPLIER AMPBELL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4641 WELDIN RD WILMINGTON, DE 19803	
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	time [R1] slip (sic) of 5/9/19 10:24 PM - A Witness Statement in the transfer of R1 9"15 PM, I walked in E6/RCT) was about I assisted with the transfer of R1 got into the air, around. Then [R1] [R1] head on the flow 5/9/19 10:52 PM - T Report from the host of a left parietal scar 5/10/19 - Clinical Procompleted by E2 (D and E7) involved in Verbal education was afety/ensuring residuring transfer, mining during transfers and sling. Both RCTs we education provided he/she would do diff 5/15/19 - The Nursing Assessment docum Committee had determing transfer due in the side of the	pt moving [his/her] and in no out of the sling to the floor." A hand written Incident by the second RCT involved , E7 ((RCT) documented "At no room (#) and (Name of it to transfer (Name of R1). So ransfer and when (Name of (Name of R1) started to move fell through the sling and hit or." The CT (special X-ray like test) spital confirmed the presence up hematoma. actice Referral/Training was ON) for both of the RCTs (E6 the transfer of R1 on 5/9/19. It is provided regarding dent was secure in sling imize resident movement and demonstrated what ferently. In 24 Hour Post Incident ented that the facility's Fall ermined R1 fell out of the sling to spasticity, as for staff to be educated on	W 15	SECTION C (System Changes) The facility's "Prevention of Ab Neglect and Exploitation, Investigation and Reporting of Alleged Incidents and Corrective Actions" policy states "any incidinvolving alleged abuse (verbal, physical or emotional) or any incident involving serious bodily injury must be reported immediated Division of Health Care Qualibut not later than two hours. All or alleged incidents must be reported within 8 hours." (Attachment A) MCC staff, consultants and contracted partners will be re-traon the need to report all suspected abuse, neglect or exploitation	etent Ately ity, In the ther ed
	was sent to E1 (AED	n e-mail from E3 (ADON))), with carbon copy of the DON) and E8 (SCM/QIDP)			

which documented, during an onsite visit by

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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CENTERS FOR MEDICARE	& MEDICAID SERVICES			MB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY_ COMPLETED
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			4641 WELDIN RD	
MARY CAMPBELL CENTER			WILMINGTON, DE 19803	
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E6 (RCT) had used extra large sling insi this may have contri. There was lack of exidentified an allegation reported this allegation reported that he/she 5/10/19 that the wrotansferring R1 on the experienced and entered R1's room to R1 secured in the sling on R1 on the experienced that he/she sling on R1 on the experienced R1's name R1's closet. E6 den wrong size sling, by (SSR1's) sling in period (DON), E2 confirmered R1's fall, which occurrenced that on the made aware by E7 (used to perform the size to transfer R1. Information, E2 went observed a sling in F1 in addition, two sling	r, E7 (RCT) verbalized that R1's roommate's (SSR1's) tead of R1's large sling and ibuted to the fall. vidence, that the facility on of neglect and immediately ion. In interview with E7 (RCT) ereported to E2 (DON) on ng sling was used in ne night of 5/9/19, when R1 all. E7 verbalized that he/she is assist E6 (RCT) who had ing. In interview with E6 (RCT) erecalled, prior to placing the vening of 5/9/19, he/she had in on the sling, which was in ited that he/she used the using R1's roommate's forming R1's transfer. During an interview with E2 d that he/she investigated irred on 5/9/19. E2 erext day 5/10/19, E2 was RCT) that SSR1's sling was transfer and it was the wrong In response to this new	W 15	SECTION D (Success Evaluation) The Exect Director, Assistant Executive Director, Director of Nursing and/or Assistant Director of Nursing will review fall incide to ensure there was no evider of a failure to provide goods services necessary to avoid physical harm, mental anguis mental illness." An audit too been developed for reviewing falls to ensure compliance withe facility's Prevention of Abuse, Neglect and Exploitar Investigation and Reporting Alleged Incidents and Correct Actions" policy. (Attachmen The review process will begin August 19, 2019 and continuuntil 100% compliance is achieved for six consecutive months. Audit results will be reviewed at quarterly Quality Assessment and Assurance Committee meetings.	dents nce and sh or of has etive t B) n

observed the sling to confirm that the wrong sling was utilized. E2 indicated in response to this fall,

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			ATE SURVEY
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	MARY CAMPBELL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4641 WELDIN RD WILMINGTON, DE 19803		
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W 153	regarding safety/en sling during transfer movement during trappropriate sizing overbalized that it was definition of neglect willful act" against a that there was lack willful act by E6 (RC confirmed that he/s allegation of neglect. The facility failed to neglect and failed to allegation, which was the facility on 5/10/1. The findings were re-	ion to both E6 and E7, suring resident was secure in r, minimizing resident ransfer and ensuring of the sling. Furthermore, E2 as her/his understanding, the included "intent to harm and a resident, thus, E2 determined of intent to harm and not a CT) or E7. Therefore, E2 she did not identify this as an t. E2 identify an allegation of a brought to the attention of 19. eviewed on 7/31/19 beginning 20 PM, during an exit meeting	W 15	53		9-27-19



Office of Long Term Care

Residents Protec-

DHSS - DHCQ 3 Mill Road, Suite 308 Wilmington, Delaware 19806 (302) 421-7400

STATE SURVEY REPORT

Page 1 of 8

NAME OF FACILITY: Mary Campbell Center

tion

DATE SURVEY COMPLETED: July 31, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTIONOF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced complaint survey was conducted at this facility from July 30, 2019 through July 31, 2019. The deficiencies contained in this report were based on observation, interview, review of clients' records and review of other facility documentation as indicated. The facility census the first day of the survey was 48. The survey sample totaled three residents and one sub-sampled resident.		
	Regulations for Skilled and Intermediate Care Facilities Scope		
3201.1.2	Nursing facilities shall be subject to all applicable local, state and federal code requirements.		
	This requirement is not met as evidenced by:		
	All incident reports whether or not required to be reported shall be retained in facility files for three years. Reportable incidents shall be communicated immediately, which shall be within eight hours of the occurrence of the incident, to the Division of Long Term Care Residents Protection. The method of reporting shall be as directed by the Division.	"All incident reports whether or not required to be reported shall be retained in facility files for three years. Reportable incidents shall be communicated immediately, which shall be within eight hours of the occurrence of the incident, to the Division of Long-term Care Resi-	
3201.9.8	Reportable incidents are as follows:	dents Protection. The method of re- porting shall be directed by the Di- vision."	
		vision.	

Provider's Signature

eg_Title

Executive Virector Date

8/29/19



Office of Long Term Care Residents Protec-

tion

STATE SURVEY REPORT

Page 2 of 8

NAME OF FACILITY: Mary Campbell Center

DATE SURVEY COMPLETED: July 31, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTIONOF DEFICIENCIES	COMPLETIO DATE
	Neglect, mistreatment or financial exploitation as defined in 16 Delaware Code,	3201.9.6, continued	
	§1131. This requirement is not met as evidenced by: Based on record review, interview, and review of the facility policy and procedure, was determined that for one (R1) out of two sampled residents who had experienced a fall, the	SECTION A (Individual Impacted) Resident (R1) was impacted by this deficient practice. Resident (R1) was impacted by this deficient prac- tice. On 5/10/19, the RCT's in- volved in the incident were edu- cated by the DON regarding use of proper sling size. SigmaCare (EHR)	
	facility failed to immediately report an allegation of neglect. Findings included: CMS Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) Regulations, with a revision date of 4/13/18,	care plans were updated to include sling sizes for residents who use mechanical lifts for transfers. On 5/28/19, the Staff Educator sent the following SigmaCare message to	
	stated the definition for neglect as: "Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness."	Healthcare staff: "In SigmaCare, under the Resident Summary page, the Transfers option under the CNA tab has been updated to reflect the	
	The facility's policy and procedure, titled Prevention of Abuse, Neglect, and Exploitation Investigation and Reporting of Alleged Incidents, and Corrective Action, with a revision date of 8/8/18 indicated: "C. IDENTIFICATION AND DEFINITIONS:	correct sling size for any residents using the ceiling lift. Please note that the size of the sling is determined by physical therapy. Thank you"	
	Regulations for ICF/IID and Long-Term Care Nursing Facilities define abuse, neglect, and	SECTION B (Identifying Other Residents)	
	exploitation, as follows: Neglect: 1. Includes situation that constitutes evidence of poplest if residents are involved in	All residents had the potential to be affected by the deficient practice. Falls from 5/1/19-7/31/19 will be	
	dence of neglect if residents are involved in serious incidents caused by one or more of the following: a. Includes lack of attention to physical needs	audited using the Audit for Tags W-153, 3201.9.6 Tool to identify falls that may have been the result	
	of the resident including, but not limited to toileting, bathing, meals and safety. F. REPORTING:3Any incident involving alleged abuse (verbal, physical or emotional)	of neglect. If the audit of fall documentation reveals evidence of neglect, the incident will be immediately reported to the Division of Healthcare. (See Attachment B)	



Residents Protec-

DHSS - DHCQ 3 Mill Road, Suite 308 Wilmington, Delaware 19806 (302) 421-7400

STATE SURVEY REPORT

Page 3 of 8

NAME OF FACILITY: Mary Campbell Center

tion

DATE SURVEY COMPLETED: July 31, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTIONOF DEFICIENCIES	COMPLETION DATE
	or any incident involving serious bodily injury must be reported to the Division of Health Care Quality, but no later than two hours af-	3201.9.6, continued	
	ter the allegation/incident occurs. All other alleged incidents must be reported within 8 hours"	SECTION C (System Changes) The facility's "Prevention of Abuse, Neglect and Exploitation,	
	The review of R1's clinical record, the facility's incident report and the facility's investigation revealed the following:	Investigation and Reporting of Alleged Incidents and Corrective Actions" policy states "any incident involving alleged abuse (verbal,	
	4/1/01 - R1 admitted to the facility with diagnoses including epilepsy and adjustment disorder.	physical or emotional) or any incident involving serious bodily injury must be reported immediately to Division of Health Care Quality,	
	5/9/19 9:00 PM - The facility's Accident Report documented that R1 was being transferred into bed from a shower chair using a sling and R1 fell through sling. R1 appeared to have hit his/her head on the floor, E6 (RCT) notified nurse who immediately performed assessment. "resident reported pain in back of head, resident was transported to hospital for evaluation." "Contributing fac-	but not later than two hours after the allegation/incident occurs. All other alleged incidents must be re- ported within 8 hours." (Attachment A) MCC staff, consultants, and con- tracted partners will be re-trained on the need to report all suspected abuse, neglect or exploitation.	
	tors: resident has involuntary spasms." 5/9/19 9:00 PM - A hand written Incident Witness Statement by E6 (RCT) documented "while transferring [R1] kept moving [his/her] and in no time [R1] slip out of the sling to the floor."	SECTION D (Success Evaluation) The Executive Director, Assistant Executive Director, Director of Nursing and/or Assistant Director of Nursing will review fall inci- dents to ensure there was no evi- dence of a failure to provide goods	
	5/9/19 10:24 PM - A hand written incident Witness Statement by the second RCT involved in the transfer of R1, E7 (RCT) documented "At 9"15 PM, I walked into room (#) and (Name of E6/RCT) was about to transfer (Name of R1). So I assisted with the transfer and when (Name of R1) got into the air, (Name of R1) started to move around. Then	and services necessary to avoid physical harm, mental anguish or mental illness." An audit tool has been developed for reviewing falls to ensure compliance with the facility's Prevention of Abuse, Neglect and Exploitation, Investigation and Reporting of Alleged Incidents and	

Provider's Signature agma (choly Title Executive a) inches Date 8/29/19



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[R1] fell through the sling and hit [R1] head on the floor."	(Attachment B) 3201.9.6, continued	
5/9/19 10:52 PM - The CT Report from the hospital confirmed the presence of a left parietal scalp hematoma. 5/10/19 - Clinical Practice Referral/Training was completed by E2 (DON) for both of the RCTs (E6 and E7) involved in the transfer of R1 on 5/9/19. Verbal education was provided regarding safety/ensuring resident was secure in sling during transfer, minimize resident movement during transfers and ensure appropriate sizing of sling. Both RCTs verbalized understanding of education provided and demonstrated what he/she would do differently.	The review process will begin on August 19, 2019 and continue until 100% compliance is achieved for six consecutive months. Audit results will be reviewed at quarterly Quality Assessment and Assurance Committee meetings.	
5/15/19 - The Nursing 24 Hour Post Incident Assessment documented that the facility's Fall Committee had determined R1 fell out of the sling during transfer due to spasticity. Recommendation was for staff to be educated on use of proper sized sling.		
5/15/19 1:28 PM - An e-mail from E3 (ADON) was sent to E1 (AED), with carbon copy of the same e-mail to E2 (DON) and E8 (SCM/QIDP) which documented, during an onsite visit by DHQC's Investigator, E7 (RCT) verbalized that E6 (RCT) had used R1's roommate's (SSR1's) extra large sling instead of R1's large sling and his may have contributed to the fall.		
There was lack of evidence, that the facility dentified an allegation of neglect and immeliately reported this allegation.		
his The der liat 7/3	may have contributed to the fall. re was lack of evidence, that the facility of tified an allegation of neglect and imme-	may have contributed to the fall. re was lack of evidence, that the facility of the facility

Provider's Signature James Colo Log Title Executive Director Date 8/29/19



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	5/10/19 that the wrong sling was used in	H	
	transferring R1 on the night of 5/9/19, when		
	R1 had experienced a fall. E7 verbalized that		
	he/she entered R1's room to assist E6 (RCT)		
	who had R1 secured in the sling.		
	7/31/19 9:30 AM - An interview with E6 (RCT)		
l/	revealed that he/she recalled, prior to placing		
	the sling on R1 on the evening of 5/9/19,		
	he/she had observed R1's name on the sling,		
	which was in R1's closet. E6 denied that		
	he/she used the wrong size sling, by using		
	R1's roommate's (SSR1's) sling in performing		
	R1's transfer.		
	7/31/19 10:30 AM - During an interview with		
	E2 (DON), E2 confirmed that he/she investi-		
	gated R1's fall, which occurred on 5/9/19. E2		
	verbalized that on the next day 5/10/19, E2		
	was made aware by E7 (RCT) that SSR1's sling		
	was used to perform the transfer and it was		1
	the wrong size to transfer R1. In response to		
	this new information, E2 went into R1's room		
	and observed a sling in R1's closet with R1's		
	name. In addition, observed two slings hang-		
	ing in SSR1's closet with SSR1's name. E2 ver-		
	balized when the fall occurred on 5/9/19, no		
	staff observed the sling to confirm that the		
	wrong sling was utilized. E2 indicated in re-		
	sponse to this fall, E2 provided education to		
	both E6 and E7, regarding safety/ensuring		
	resident was secure in sling during transfer,		
	minimizing resident movement during trans- fer and ensuring appropriate sizing of the		
	sling. Furthermore, E2 verbalized that it was		
	her/his understanding, the definition of ne-		
	glect included "intent to harm and willful act"		
	against a resident, thus, E2 determined that		
	there was lack of intent to harm and not a		
	willful act by E6 (RCT) or E7. Therefore, E2		

Provider's Signature

Cheng Title Executive Director Date 8/29/19



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confirmed that he/she did not identify this as an allegation of neglect. The facility failed to identify an allegation of neglect and failed to immediately report the allegation, which was brought to the attention of the facility on 5/10/19. The findings were reviewed on 7/31/19 beginning at approximately 3:00 PM, during an exit meeting with £1(Assistant ED) and £2(DON). 9/27/19	SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTIONOF DEFICIENCIES	COMPLETION
		an allegation of neglect. The facility failed to identify an allegation of neglect and failed to immediately report the allegation, which was brought to the attention of the facility on 5/10/19. The findings were reviewed on 7/31/19 beginning at approximately 3:00 PM, during an exit meeting with E1(Assistant ED) and		9/27/19

Provider's Signature



_Title &ccultur Director Date

8/29/19



Office of Long Term Care

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DHSS - DHCQ 3 Mill Road, Suite 308 Wilmington, Delaware 19806 (302) 421-7400

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